

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-031064

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 144

STATE FILE NUMBER

FILED JUL 23 1963

1. PLACE OF DEATH a. COUNTY <b>Vernon</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Vernon</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Nevada</b>		c. CITY OR TOWN <b>Nevada</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>		Length of stay in 1b <b>25 Yrs.</b>	d. STREET ADDRESS (If outside, give location) <b>215 S. Pine</b>
		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) <b>Orville Owen Grimes</b>			4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>4/10/85</b>	9. AGE (last birthday) <b>68</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RailRoad</b>		11. BIRTHPLACE (City and state or country) <b>Bourbon Co. Kan. U.S.</b>	
13a. FATHER'S NAME <b>Charles Grimes</b>		13b. MOTHER'S MAIDEN NAME <b>Hester Kirby</b>		14. NAME OF HUSBAND OR WIFE <b>Florence Grimes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT <b>P. F. Marshall. Nevada, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Coronary arteriosclerosis</b>		<b>Unknown</b>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchial pneumonia - Uremia</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from **Sept. 1 1955** to **July 15 1963** and last saw him alive on **July 15, 1963**  
Death occurred at **Nevada, Mo.** on **July 15, 1963** at **19:05** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>L. P. McCann</i>	22b. ADDRESS <b>Moore Bldg., Nevada, Mo.</b>	22c. DATE SIGNED <b>7/16/63</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/17/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Prescott, Kansas</b>
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24. FUNERAL DIRECTOR <b>Richard L. Shorten. Nevada, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7-20-1963</b>	26. REGISTRAR'S SIGNATURE <i>Anna E. Ferry</i>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

APR 8 1964

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. 4853

P. O. Address Florida, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.